Publicly Reported Physician Ratings:
Here to Stay But Not Yet Ready for Prime Time

By Diane Shannon, MD, MPH

In this article...

Take an in-depth look at physician rating services and see what doctors think about the future of quality measurements.

Public reporting of physician performance—whether user-generated physician rating websites or metrics-driven, scientifically based performance reports—is a reality of health care today and is increasingly tied to high-stakes outcomes, including reimbursement and compensation.

With the rise of the consumerism movement, more and more patients are proactive in choosing their providers and are increasingly turning to the Internet to make their selection and to voice their opinions about providers with whom they have interacted.

In the past, patients’ conversations about their physicians largely consisted of informal discussions with friends, family members and acquaintances that extended no further than the two or three individuals involved. With the Internet, these conversations now have rapid and widespread distribution via online physician rating websites. And they can affect physicians’ reputations.

The stakes associated with metrics-driven physician performance assessments are also greater than in the past. As the cornerstone of the delivery system, physicians exert significant influence through clinical decision-making on the quality and cost of health care.1

Many stakeholders are looking to individual physician performance ratings with the goal of standardizing care with best practice guidelines and thus improving quality and cost efficiency.

Governmental agencies, payers, advocacy groups and consumers are more frequently demanding transparency in physician performance than in the past, as a means for improving the quality and cost efficiency of health care.

Payers are using rating systems to identify physicians deemed to provide care of higher quality and greater cost efficiency and are offering patients benefit plans that incentivize the selection of higher-ranking physicians.

As the outcomes of physician ratings are increasingly tied to reimbursement and compensation, the validity, reliability and relevance of these systems becomes crucially important.

It is important for physician leaders to understand the current state of physician ratings systems, the likely future trends, the potential utility and negative consequences of ratings systems, and how to best guide their organizations to make the most of the opportunities afforded by these systems and minimize the potential risks.

Two major camps

Two basic types of publicly reported ratings of individual physician performance exist: user-generated online rating websites and systematic, metrics-based assessments.

The two camps vary in mission, funding, items measured, degree of transparency, and rigor of the scientific method used. However, there is significant overlap between the two types of ratings and increasing convergence over time.

For example, the user-generated online website DrScore is designed as a service for physicians, providing specific feedback on the satisfaction of their patients with practice efficiency, access, care coordination and quality.

In contrast, when completed, the metrics-based, federally funded Physician Compare website will allow consumers to select physicians based on metrics-driven performance data.

Who’s rating whom?

Online rating sites are commonplace in other sectors of the economy, but are a relatively new development in health care. Other professionals, including writers, restaurant owners and filmmakers, have dealt with this form of social media for some time.2
Comparing the two types of physician rating systems

<table>
<thead>
<tr>
<th></th>
<th>User-generated online rating websites</th>
<th>Systematic, metrics-based assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td>RateMDs, Angie’s List, DrScore</td>
<td>Health plan sites, Physician Compare, organizational surveys using CG-CAHPS*</td>
</tr>
<tr>
<td>Mission</td>
<td>Provide consumers with information to compare and select physicians; provide a forum for exchange of opinion</td>
<td>Provide feedback for physicians and organizations on performance; create a system for performance incentives</td>
</tr>
<tr>
<td>Funding</td>
<td>Various business models, include fees paid by physicians or other users, advertising, non-profit</td>
<td>Insurers, governmental agencies, nonprofit groups, multi stakeholder coalitions</td>
</tr>
<tr>
<td>Items measured</td>
<td>Patient satisfaction</td>
<td>Quality, cost, safety, patient experience, patient satisfaction</td>
</tr>
<tr>
<td>Degree of transparency for methodology</td>
<td>Generally less</td>
<td>Generally more but variable</td>
</tr>
<tr>
<td>Rigor of scientific method used</td>
<td>Generally less</td>
<td>Generally more</td>
</tr>
<tr>
<td>Use of National Quality Forum (NQF) metrics</td>
<td>Rarely</td>
<td>Often</td>
</tr>
<tr>
<td>Methods used to prevent use of falsified data</td>
<td>Variable, can be vulnerable to false postings</td>
<td>Generally more rigorous</td>
</tr>
</tbody>
</table>

*Clinician/Group-level Consumer Assessment of Healthcare Providers and Systems
Driven in part by pressure from large employers to control costs, many health plans provide rating or tiering of physicians.

According to David Ferriss, MD, MPH, senior medical director of Cigna’s Lifestyle Medicine Associates, the insurer developed an online directory of physicians in 2005 that has progressively included more information related to performance improvement.

“Cost-efficiency and quality displays are now available for 19 specialties, with three more to come in 2013.” The insurer’s cost-efficiency index is calculated using episode treatment groups (ETG) methodology. The quality index is based on the use of evidence-based medicine rules.

Responding to client interest, the insurer launched a Cigna Care Designation (CCD) in January 2005. An icon in the directory indicates which physicians have ranked in the top tier for quality and cost-efficiency. Some Cigna clients are now designing benefits for their employees that include reduced copays or co-insurance if these physicians are selected.

Governmental agencies

The Centers for Medicare and Medicaid Services (CMS) has garnered a great deal of attention for its Physician Compare website, currently under development. As mandated by the Accountable Care Act (ACA), the Physician Compare site was implemented by renaming the CMS health care directory to Physician Compare in December 2010.

The site currently includes contact information and other demographic data for physicians who are enrolled Medicare providers. It also provides information about physicians and other eligible professionals who participate in the Physician Quality Action Networks (PQAN) program and the Institute for Healthcare Improvement’s California HealthCare Foundation/California Evidence Alliance.”

Measuring Satisfaction Versus Experience

User-generated rating websites generally provide information on patient satisfaction, either in the form of numerical ratings or narrative comments.

Questions used to assess satisfaction include, “How likely are you to refer a friend or relative to this physician?” and “How satisfied are you with the care provided by this physician?”

In contrast, systematic, metrics-driven ratings that measure the patient experience of care generally rely on questions that determine whether the patient observed certain behaviors on the part of the provider.

For example, the CG-CAHPS includes the question, “In the last 12 months, how often did you see your provider within 15 minutes of the appointment time?”

According to Aligning Forces for Quality (AF4Q), a national improvement endeavor launched by the Robert Wood Johnson Foundation, measuring the patient experience provides specific actionable data unavailable from a global satisfaction score.

Generally these sites provide basic facts about a physician such as contact information, number of years in practice, board certification, residency, malpractice experience and any disciplinary actions. They also allow patients to enter reviews using a numerical scale and open comment feature.

There are four main funding sources for user-generated physician rating sites:

1. Health insurers
2. Government agencies
3. Privately held companies
4. Nonprofit organizations

Health insurers’ sites allow their customers to compare physicians covered by their health plan. Local governments offer sites with information from state databases about the physicians who are licensed in their jurisdiction.

For example, the Maryland Board of Physicians Practitioner Profile System lists physicians’ office address, status of license, and any disciplinary actions, criminal convictions or malpractice awards or settlements.

Some privately held sites, such as Angies List and CastleConnelly, charge patients a membership fee for accessing information about physicians. Other privately owned sites, such as DrScore and RateMDs, are free for patients and funded either through advertising or fees to physicians or hospitals.

Professional advocacy groups, such as the American College of Surgeons, and other not-for-profit organizations, also offer physician rating information to patients for free, although the data may be limited to basic facts about a physician.

The sites vary in their policies regarding entering ratings and posting comments. Some sites prohibit anonymous postings, use a screening process to remove falsified entries, and provide a feature for replies to comments; others do not.

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FOCUS

No one brings you more physician-specific benefits, because insurance for physicians is what we do. Period.
Reporting System or the Electronic Prescribing Incentive Program.

Although the site currently does not include quality performance data, the ACA requires that CMS develop a plan by January 1, 2013, for adding physician performance information.3

According to Regina Reymann Chell, acting division director, Division of Ambulatory Care and task lead in the Quality Management and Health Assessment Group in CMS’ Center for Clinical Standards and Quality, the overarching goals of the Physician Compare site are to respond to a consumer need for additional information, to encourage informed patient choice, and to create incentives to maximize providers’ performance.

“We are undergoing a redesign to significantly improve the underlying database and the information on the site, as well as to improve the ease of use and functionality, before adding quality information.” CMS continues to release the phase-in approach of its plans for the site, including proposed quality metrics, over time to allow for consumer and provider feedback. Initially the site will include quality data on physician group practices. Later, the site will also post data on the performance of individual physicians.

**State and regional coalitions**

A number of state and regional coalitions collect and publicly display physician-specific performance data. Some of these are publicly funded; others are funded by nonprofit organizations or regional collaborative organizations supported by provider systems, large employers and other stakeholders.4

For example, the Colorado Business Group on Health recently published a report on individual physicians’ performance on diabetes and cardiac care, with a special designation for those who achieve the highest rankings in both clinical areas.5

**Individual provider organizations**

Provider organizations—or their hired data management or consulting partners—commonly generate ratings of individual physician performance, although at present these are not often publicly displayed.

With the 2010 Joint Commission Ongoing Professional Practice Evaluation (OPPE) requirements, health care organizations now must regularly collect data to assess individual physicians in six core competencies.6 Notably, two of the competencies, patient care and interpersonal and communication skills, relate to patient satisfaction and experience of care.

Sherif Abdou, MD, president and CEO of HealthCare Partners Nevada, a multispecialty physician group of 200 primary care physicians and more than 1,300 specialists, says his organization routinely assesses individual physicians using metrics that gauge resource utilization, quality of care and patient satisfaction.

According to Abdou, results have a direct effect on the physician’s bottom line.

“Bonuses for the profit-sharing agreement are based one third on patient satisfaction scores, one third on quality outcomes, and one third on meeting budgetary goals.”

Bonuses are paid on top of base salaries rather than through a withhold to be paid only if conditions are met. Unblinded results are shared quarterly within the organization but are not shared externally.

**How much are physician ratings being used?**

User-generated physician rating sites don’t receive high traffic although uptake appears to be increasing. According to a 2008 Harris Poll commissioned by the California Healthcare Foundation, only 26 percent of Internet users reported that they sometimes or often used these sites to find ratings of physicians, up from 19 percent in 2004.8

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**A Familiar Name Enters the Arena**

A well-known entity entered the physician-rating arena recently, although the organization’s rating system evaluates physician groups, rather than individual physicians.

*Consumer Reports*, known for reviews of televisions and refrigerators, teamed up with Massachusetts Health Quality Partners (MHQP) to rate the quality of the patient experience at almost 500 primary care practices in the state.7

A summary of results was published in mid-2012 in a special version of the *Consumer Reports* magazine. MHQP, a coalition of hospitals, physicians, government agencies, insurers and consumers, has conducted patient experience surveys across the state and reported the results publicly since 2006.
Outcomes of physician ratings are increasingly tied to reimbursement and compensation.

A more recent study by Deloitte, the consulting firm headquartered in New York, found that 47 percent of Internet users had sought information about their providers online and 37 percent had consulted physician rating websites. Only seven percent of individuals who sought information online posted a review of their provider.

Relatively low usage is also evident in the number of online reviews of physicians. A 2010 study of 33 websites offering physician ratings found only 190 reviews for 81 physicians.

Similarly, a 2012 study documented that only one in six practicing physicians had received an online review on a national user-generated rating site. According to the co-authors of the latter study, Guodong Gordon Gao and Ritu Agarwal, co-directors of the Center for Health Information and Decision Systems at the University of Maryland School of Business, use of the website increased from 2005 to 2010.

“The growth was striking in three ways: the numbers of reviews per physician, the number of physicians rated, and the presence of ratings across all clinical specialties.”

In contrast, use of metrics-driven performance ratings of individual physicians is widespread. State governmental agencies began publishing report cards of physicians’ performance in coronary artery bypass graft procedures as early as the 1990s.

Large payer groups, community coalitions, the federal government and private payers have developed metrics-based report cards on individual physicians.

These ratings are neither standardized nor governed by a single oversight body.

According to David B. Nash, MD, MBA, dean of the Jefferson School of Population Health at Thomas Jefferson University in Philadelphia, “Ratings of physicians is a huge issue and the punch line is this: There is no central repository for physician ratings. It is literally all over the map.”

Consumers appear to access metrics-driven physician performance data infrequently. A 2008 telephone survey commissioned by the Kaiser Family Foundation documented that only 12 percent of interviewees had seen information comparing physician quality performance.

However, interest in Physician Compare appears to be relatively strong. According to Chell, the site tallied 1,298,163 page views in September 2012.

Evidence of growth in the use of user-generated and metrics-based rating systems, combined with market pressure to engage the consumer in improving cost efficiency and ACA-mandated public reporting of performance measures, suggest that publicly displayed performance ratings of individual physicians is poised for expanded use.

Complaints mount

According to Helen Haskell, patient advocate and founder of Mothers Against Medical Error, user-generated sites are “helpful but not helpful enough. There’s often not enough information or volume of reviews to be helpful to a lot of patients.”

Small sample size has been a widespread complaint among consumers and physicians. According to the Gao study, the average number of ratings per physician was just 3.3.

Likely the most common complaint among physicians about the user-generated rating sites is the risk that a disgruntled patient will significantly harm a physician’s professional reputation and business standing.

Both physicians and professional societies have voiced concerns about the potential for widespread damage to physicians’ reputations online—and the inability to reply to patient postings due to concerns.

Despite Fears, Most Reviews are Positive

Despite concerns, the majority of online physician reviews are positive. A 2011 study of the 10 most visited physician rating websites found that on average physicians received ratings equivalent to about 77 out of 100.

Gao and colleagues found that online ratings on RateMDs averaged a score of 3.93 on a scale of 1 to 5, with higher numbers indicating a more positive response. Half of the physicians rated on the site received a score of.

According to Steven R. Feldman, MD, PhD, professor of dermatology, pathology and public health sciences at the Wake Forest University School of Medicine and president of DrScore, physician ratings on the DrScore site for doctors with 10 or more reviews average 9.3 out of 10.
about maintaining patient confidentiality. Interestingly, research on these sites has shown that the majority of reviews are positive.

Despite the generally positive ratings of physicians, user-generated physician rating websites have garnered legal action. Last year, a neurologist in Minnesota lost a bid to sue a patient’s son for defamation.

The man had posted numerous negative online reviews and lodged complaints with the state medical board and other professional oversight groups about the physician’s treatment of his father.10

In 2009, the state of New York settled a complaint against a company that posted falsified online consumer reviews of its cosmetic surgery procedure.11 The Attorney General’s office had accused the company of violating consumer protection laws. Although the case did not involve a physician ratings site, it could serve as a cautionary tale for physicians whose staff might be tempted (or asked) to post positive reviews on his or her behalf.

Another concern with user-generated rating sites is the quality of the metrics used. Some physicians feel that the items tallied on user-generated rating sites do not measure the true quality of care provided by the physician, but instead reflect the level of patient satisfaction with factors that may be beyond the realm of physician control.

“One of the metrics Consumer Reports felt strongly about including was, ‘How strongly would you recommend this physician to friends or family?’ Physicians objected, feeling that the question could reflect issues with copay, staff, the office environment—not medical care.” Ultimately, the question remained in the survey.

Similarly, critics have argued that the authenticity of the data posted on user-generated sites are sometimes questionable.

According to Darshak Sanghavi, MD, chief of pediatric cardiology at the University of Massachusetts Medical School and a member of the Massachusetts Medical Society (MMS) advisory committee on quality measures, the question of metrics was hotly contested when the MMS committee collaborated with other stakeholders to select measures for the MHQP-Consumer Reports ratings program.

John Swapweinski, co-founder of RateMDs, says the website screens out a significant number of false positive and false negative reviews (“positive and negative spam”). The website has a two-level system to weed out the fake reviews.

First, trained employees scan each posting and remove those with offensive terms or blatant name-calling, or that express completely unrealistic expectations.

Second, an automated system filters the remaining reviews, checking for repeat postings with the same IP address and from the same type of browser. Swapweinski estimates that 3 to 5 percent of reviews are pulled by employee scan and another 5 percent through the automated system.

Metrics-driven sites flawed

In their current state, metrics-driven physician rating systems have their share of issues as well. Critics argue that the data type, metrics, risk adjustments and measurement methodology are flawed.

Administrative or claims data, rather than clinical data, have formed the basis for much of the publicly reported quality data on individual physicians, leading to concerns about the applicability and clinical relevance of results based on these data. In addition, certain specialties have few evidence-based rules as yet upon which to apply quality metrics.

Physicians frequently object that the selected metrics do not assess the true quality of care provided. The American Medical Association (AMA) has referred to the lack of transparency and physician input regarding metrics selection and measurement calculation as “black box” methodology.18,19

In a 2010 letter to CMS, the AMA cautioned for judicious development of the Physician Compare site, especially in regard to the current state of availability and use of “clinically relevant and electronically specified quality measures, as well as tested and widely used risk-adjustment and attribution methodologies.”19

The letter strongly recommended that physicians play a lead role in the development and selection of performance measures to be used for public performance reporting.

With the significant professional and financial consequences of publicly shared reviews, objections and perceived missteps in metrics-driven ratings have led in some cases to legal actions.

In 2011 the California Medical Association (CMA) filed a lawsuit to prevent the use of a quality rating program created by Blue Shield of California because of objections about the rating methodology.20

The case was rejected, with the court ruling that the program was protected under freedom of speech laws and that the CMA had failed to show that the insurer’s program resulted in business losses for the physicians.

In 2008 the Massachusetts Medical Society and five physicians brought a defamation suit against Group Insurance Commission, which oversees insurance for public employees, claiming the tiering methodologies used by the insurer were invalid and inaccurate.21

Eventually, a state judge dismissed the case, finding that there
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Potential benefits

Both user-generated and metrics-driven rating systems offer benefits, even with their current limitations.

According to Richard V. Aghababian, MD, Massachusetts Medical Society president, “One of the values of these systems is that physicians who don’t receive a good rating can use the information as a part of the knowledge and skill self-assessment process. This information can then be used to select ongoing medical education activities that will attempt to fill in gaps in the areas of weakness. Ongoing assessment and planning for improvement activities may involve collaborating with other health care professionals and/or office staff. It is likely that the best clinical outcomes for patients will be achieved if all members of the health care team are working together.”

Aghababian feels that this feedback is especially important in improving the patient-physician relationship, which he sees as essential to gaining and maintaining patient adherence with clinical goals and treatment plans.

Feldman conceived of the DrScore website because of his own experience as a dermatologist. Negative patient comments about his bedside manner led him to improve his communication skills. He realized, “Physicians need feedback from their patients, just like any other business needs feedback from its customers.”

The site provides physicians with both numerical ratings and comments from patients—although only the ratings are publicly displayed. “I see the feedback as a gift to becoming a better doctor,” he said. According to Feldman, improvement in ratings can have a financial benefit as well: some physician clients of the DrScore site have used their satisfaction scores to negotiate higher fees with insurers.

What Do Consumers of User-generated Sites Care About?

Research conducted by Feldman on ratings posted on DrScore site found that the strongest correlate of patient satisfaction was perceived empathy, or “a caring, friendly attitude.” Other statistically significant correlates included less waiting time and more time spent with the physician.

A survey conducted by the consulting firm PricewaterhouseCoopers found that almost three quarters of queried consumers ranked provider reputation and personal experience as the strongest factors influencing their choice of providers. Respondents also valued convenience and friendly staff attitude.

Some basic information about physician performance can be difficult for consumers to access. According to Haskell, “It’s hard to get information about ‘dangerous doctors’ from state medical boards and national practice databases. One physician I know of finished 10 years in prison for Medicare fraud, only to obtain a new license and a clean record when he was released.”

Finally, two major concerns about the use of metrics-driven physician rating systems are preserving health care access and implementing balanced risk-adjustment methodologies for patients with co-morbid conditions or who are otherwise at risk for incurring higher costs.

As seen historically with the first publicly displayed physician report cards, physicians may select healthier patients to ensure better outcome scores.

Use of agreed-upon risk-adjustment methodologies will be important to avoid similar scenarios in the future.

Almost three-quarters of public reporting experts interviewed in the study identified the lack of consumer understanding and appreciation of quality variation among providers as a significant barrier to consumer-directed public reporting.

One significant issue with metrics-driven sites for consumer use has been balancing the consumer’s desire for information on individual physicians and the generally small volume of data associated with a single provider, leading to issues with validity.

Metrics-driven rating systems are often difficult for consumers to interpret and understand. A 2012 survey of stakeholders in consumer-directed public reporting concluded that “public reporting has been disconnected from consumer decisions about providers because of weaknesses in report card content, design and accessibility.”

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scores when negotiating reimbursement rates with insurers.

Similarly, metrics-driven rating systems can help drive improvement in care, although according to many experts, the flaws currently outweigh the benefits.

The AMA supports only limited use of physician quality results: “Although the AMA believes that quality measurement is still too imprecise to publicly report or to use in steering patients to certain physicians, we do strongly support using it to identify quality improvement opportunities for individual physicians and practices.”

The Robert Wood Johnson Foundation initiative, AF4Q, has gathered preliminary data showing that public reporting of physician performance using measures that are selected at the local level with physician input improves physician performance on preventive care metrics.25

Bridging the gap

According to experts, a wide gap exists between the current state and the ideal—physician rating systems that provide accurate, relevant, easily understood metrics for patients and other users; actionable, reliable, valid feedback for physicians; and a valid foundation for incentives to support improved care quality, safety, and cost efficiency.28, 29, 13, 1

Metrics are often viewed as irrelevant and chosen without physician or consumer input; measurement and risk adjustment methodologies are often applied without transparency and validation; and inadequately sized samples are sometimes used in calculations comparing individual physicians.

Some experts are concerned that because of the paucity of

User-generated physician rating websites have garnered legal action.
consumer-oriented, metrics-driven information on physician performance, consumers will increasingly turn to user-generated sites as their only alternative.30

According to Gao, “Patients are relying more and more on the Internet to find physicians. It boils down to what information is available for them to use when selecting a doctor.”

Sanghavi agrees. “Is the currently available information ideal? No. We have a long way to go. We need to find measures that are meaningful to both patients and physicians. We need websites that arrange the data in a more user-friendly format.”

He also believes that quality measures need to be more sophisticated—specific outcomes-oriented data for example, rather than a global score on complication rate—and that measurement needs to include patient experience metrics, since these will be used in value-based payment.

Nash reiterates the likelihood of physician performance metrics being increasingly tied to reimbursement. “Under health reform, we will be paid to do a better job. Moving forward, there may be a lower payment, or possibly no payment, for poor outcomes. We could describe the future as ‘No outcome, no income.’”

Given the high stakes, Aghababian feels that a fair adjudication process is essential. “We want tiering processes to include patient feedback, patient outcomes, and consideration of the complexity of the patient’s medical condition. In addition, a senior physician in the field needs to judge the quality and make adjustments if a certain physician’s practice includes many patients with diabetes, for example. We want comparisons to be fair.”

A number of experts point to the future release of a fully operational Physician Compare site as a watershed event, if the site is crafted to avoid the many potential pitfalls.

In a 2010 article, David Lansky and Steven Findlay, members of the Consumer Purchaser Disclosure Project, a consortium of purchasers, called the site a potential “game changer” if CMS is able to overcome a number of major hurdles.29

The challenges they list include the:

• Need to select measures that matter to patients
• Desire for consumers to obtain information on individual physicians despite the validity problems associated with small sample size
• Availability of comprehensive patient data, preferably from all-payer databases to encourage improved care for all patients
• Accuracy of the data used
• Need for an efficient process to respond to any inaccuracies in the data
• Need to better inform consumers about the presence of the site

As a researcher, Gao is hopeful that the Physician Compare site will provide data on quality performance that are currently not available.

His co-author on the project, Agarwal, predicts a significant change in physician disclosure about performance results in the wake of increasing public disclosure. “I believe that within the next few years physicians who care about maintaining a relationship with their patients and about their place in the market will begin to voluntarily disclose quality results on their practice websites.”

In addition, expanding the availability of non-claims-based data with new technology could radically alter the field, according to Ferriss. “I think there will be a dramatic change within the next three to five years, as electronic medical records are increasingly used. Better clinical databases will help increase the validity and the reliability of the data available for comparing physicians’ performance.”

Five key strategies for physician leaders

Physician rating systems are not currently at an ideal state, and physician leaders can play an important role in guiding their organizations to better understand, use and respond to the existing systems. Here are five key strategies to consider:

1. Educate yourself and your colleagues. Go online and check your ratings. (If you’re no longer practicing, check those of a colleague or two.) Check user-generated sites that you identify through a search engine and professionally maintained sites, such as those of a professional advocacy group. Review your current ratings on health plan sites as well. Encourage colleagues to do the same.

2. Respond with care. If you find negative or inaccurate ratings, investigate your options for responding. Consider carefully whether and how to respond. Privacy concerns prohibit physicians from responding with specifics, but responding to a complaint about a long wait in the exam room with “Thanks, that’s something I will address” may be helpful. Contact the website owner to see if an offending comment can be removed. Consider creating your own website to present accurate information about yourself and your practice.

3. Consider legal action against user-generated comments as a last resort. Not only are defamation lawsuits expensive and time-consuming, but they also increase the chance of widespread media attention. Gag orders—requiring that patients sign releases of any information online—are used by some
physician practices, although the step has been denounced by some health care experts and consumer advocates.31, 32

4. Be proactive and vocal. Recommend that practicing physicians work with others in their field to identify ideal quality metrics and advocate for their use. Encourage them to provide feedback to CMS when the proposed quality metrics for the Physician Compare site are released.

5. Learn and adjust. Expect resistance and scrutiny of metrics and methodology for metrics-driven rating systems. Be prepared to answer detailed questions about the data and to defend the need for such systems. Encourage colleagues to glean as much information as possible from performance data and to consider carefully any feedback about the patient experience. Could new policies for front office staff behavior translate into an improved experience in the waiting room?

Conclusion

Publicly reporting of physician performance, whether based on user-generated or metrics-driven data, is likely here to stay. Although user-generated reviews and metrics-driven assessments offer opportunities to improve care, in the current state both have significant flaws.

User-generated websites often have few reviews, are based on non-standardized metrics, and have varying policies regarding the posting of reviews. Metrics-driven sites present concerns regarding metrics selection, analytic methodology and consumer access.

In the ideal world, physician rating systems would provide patients with reliable information in a user-friendly format and physicians with reliable, actionable information with which to improve their practices. Physician leaders can help steer their organizations through the quagmires inherent in the current physician performance rating systems on the journey toward that ideal.

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See related column by ACPE CEO
Peter Angood, MD, page 95.

References


